Progress on predictive modeling for the Rapid Management Enrollment Report

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Old Business: At the Dane Co Advisory Comm. Mtg. on 9/24/04, the Committee requested a report of the "predictive model" indicators aggregated for Dane County (and the other SSI demonstration sites). The SSI Managed Care Expansion Database for Calendar Years 2001, 2002 and 2003 is now final (copies available by request from David Beckfield of BMHCP). The aggregate report can now be computed from the CY 2003 data set, and delivered to the Committee.

Further discussion of the detailed contents was referred to the QA Workgroup, which met on 10/27/04. Some important points emerged from the discussion:

1. Alternate measures were proposed as superior substitutions for the earlier report indicators.
    a) For the PQI, roll the 13 indicators up into 4 groups.
    b) Use MEDDIC measures for BH and SA care.
    c) Use CCS diagnosis groups (rather than CDPS diagnosis groups).
    d) In the PM summary, include prior expenditure; revise the definition of "very high" to top 2%; revise the definition of "large increase" to top 5% of increases; re-estimate the models with the new PM/RM indicators.
2. Pharmacy data should be included, but care must be taken to select appropriate indicators. For example, a claims-based measure of "adherence" to anti-psychotic medication prescriptions does not address the issue of consumer choice, nor does it carry sufficient detail for practitioners to judge the quality of care (e.g. zyprexa v. haldol). Further discussion was referred to a pharmacy focus group.
3. Discontinuity of enrollment is a key indicator of gaps in coverage, and also gaps in data, if individuals have moved on and off of Medicaid due to employment or residence in a mental health or correctional institution. An enrollment discontinuity indicator will be added to the report.
4. All of the indicators for this report come from the Medicaid claims database, and is therefore too limited in scope to stand alone as a "quality" measurement tool. Even though it includes some claims-based quality indicators, such as the PQI and MEDDIC measures, it is not primarily intended to be a quality monitoring tool. It is intended to be a rapid management tool to help prioritize new enrollees for clinical evaluation and case management. A more thorough assessment of care quality will require data from other sources, such as consumer satisfaction surveys (CAHPS or MHSIP) and the County HSRS MH module when it becomes available to MEDS users.

Another point was brought up in the Milwaukee area QA Workgroup. There is currently no information about functional status on the PM/RM report. While it is not possible to

include “activity of daily living” functional screening items in the report, it may be possible to include some claim-based proxies for limited functional status, such as the provision of personal care services, or durable medical equipment to aid mobility.

A pharmacy focus group consisting of Dr. Urban, Dr. Diamond, Lani Holmes (pharmacist from CLA), Allan Mailloux (pharmacist from APS), and Don Libby met on November 8, 2004. Some important points emerged from the discussion:

1. The choice of measure depends on the question being asked and who is asking. A therapist may need very complex and detailed information in order to understand a customer’s needs. For purposes of the PM/RM report, we presume that a case-management specialist (social worker or nurse) will be asking “who among the newly enrolled should receive priority attention for evaluation and management”. For this purpose, less complex measures will suffice.
2. It is important that the user of this information be guided to interpret it correctly, and to avoid misinterpretations or invalid inferences. For this purpose, the PM/RM report should be accompanied by a plain-English description of the usefulness and limitations of the items on the report: a “how-to with do’s and don’ts. “
3. In order to distinguish between consumers with more complex needs from those with less complex needs, a count of the number of psychotropic medications should suffice. Anecdotal evidence suggests that those with five or more different medications in this broad therapeutic category tend to have high intensity behavioral health care needs.
4. To broaden the scope beyond behavioral health needs, medications for diabetes, at least, should be represented in the report. Also consider conditions that depend highly on prescribed medications for good outcomes: e.g. Hepatitis C.

New Business. Next steps for the PM/RM report (with suggested completion dates) are:

1. Translation of MEDDIC measures from Managed Care data to FFS data is expected to be completed by December 15.
2. When measures are complete, the PM will be re-analyzed and the output tables will be constructed by December 31.
3. When the output tables are ready, the Business Objects Web-I interface can be developed, with a demonstration version ready by Jan 31, 2005.
4. Fully operational Web-I interface with secure claim-universe drill-down capability may be ready by Mar 1, 2005.